PRINTED: 01/14/2010 FORM APPROVED Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVN4596HIC 01/04/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2000 HUMBOLDT STREET MARY KNOLL CARE HOME **RENO. NV 89509** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) H 000 **Initial Comments** H 000 Surveyor: 25375 This Statement of Deficiencies was generated as a result of a State licensure survey conducted in your facility on 1/4/10. This State Licensure survey was conducted by authority of NAC 449, Homes for Individual Residential Care, adopted by the State Board of Health on November 29. 1999. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The resident census at the time of the survey was zero. There were no former resident files or employee files available for review. The following regulatory deficiencies were identified: H 018 H 018 Director Duties-BLC&DAS Phone Numbers NAC 449.15523 Director: Duties. (NRS 449.249) The director of a home shall: 3. Ensure that the residents of the home: (b) Receive:

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

This Regulation is not met as evidenced by:

(4) The names of, and the telephone numbers for the registration of complaints with the bureau and the aging services division of the department

of human resources.

Surveyor: 25375

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
NVN4596HIC		NVN4596HIC		B. WING		01/04/2010		
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			D HUMBOLDT STREET O, NV 89509					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE		
H 018	Continued From page 1			H 018				
	Based on observation, interview and record review on 1/4/10, the director did not ensure that the names and telephone numbers for the registration of complaints with the Bureau of Health Care Quality and Compliance and the Division for Aging Services were available.							
H 019	Director Duties-No FA/CPR			H 019				
	The director of a hom 4. Ensure that a care meeting the needs of trained in first aid, and	giver, who is capable of the residents and has d cardiopulmonary e premises of the home	f been					
	Surveyor: 25375 Based on record reviet 1/4/10, the director di employees had receiv cardiopulmonary resu (Employee #1 had not Employee #2 did not training).	uscitation (CPR) and fire to current first aid training have CPR or first aid ficiency from the compl	on 2 st aid g and					
H 030	NAC 449.15525 Requirements anitation of facility. (ome Clean; Hazard Frequirements for safety and NRS 449.249) terior of a home must b	d	H 030				

Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVN4596HIC 01/04/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2000 HUMBOLDT STREET MARY KNOLL CARE HOME **RENO. NV 89509** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) H 030 Continued From page 2 H 030 clean and free of hazards and offensive odors. This Regulation is not met as evidenced by: Surveyor: 25375 Based on observation on 1/4/10, the interior and exterior of the home was not clean and free of hazards and offensive odors. Findings include: There were four smoke detectors in the facility. The smoke detector in the kitchen did not work at all and the other three smoke detectors in the house made low-battery chirping sounds. The employee reported he did not have any replacement batteries. Boarder #1 reported he had been hearing the chirping sounds for over two months. Upon entry to the facility, it was observed that the over-head entry light fixture and hallway lights did not work when turned on. Two of three table lamps in the living room did not work when turned on. The kitchen over-head light did not work when turned on. The over-head light fixtures on the ceiling of Boarder #2's bedroom had no cover or light bulbs. The bedroom of Boarder #1 had several extension cords suspended from the ceiling from a single wall outlet. The cords were connected to multiple appliances and a portable heater which was on top of an end table. See Tag H036. Through out the kitchen, dining area, living room, and the bedrooms there were numerous containers of left-over food such as chicken, shrimp, fish and some un-identifiable items in various stages of decomposition.

Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVN4596HIC 01/04/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2000 HUMBOLDT STREET MARY KNOLL CARE HOME **RENO. NV 89509** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) H 030 H 030 Continued From page 3 There were two cold pots containing a water and pork mixture on the stove. The employee reported the pork was left over from 12/31/09 (four days ago) and he was going to put it in the freezer. One side of the sink and counter spaces were covered with dirty dishes, the other side of the sink was backed up with cold greasy water. There were two cold rice-cookers with dried cooked rice in them. There were dried muffins sitting out on a ledge on top of the closed oven door and on top of a picture on the wall in the kitchen. There was a bag of unrefrigerated, room temperature cooked chicken on the kitchen table amongst trash and dirty pans and cooking utensils. There was a warm package of raw chicken on the counter near the sink. The dining table was covered with a layer of grease and on top of the table there was a baking pan with fish and shrimp coated with moldy green growth and a styrofoam container of moldy pancakes. There was a grocery bag on top of a heater vent in the living room. The bag contained liquified, decomposing food. The employee ignored repeated instructions to dispose of the unrefrigerated and spoiled food. The upstairs common area smelled strongly of urine. The kitchen floor was sticky and dirty with dried food. In the basement common area, there were ashes on the table and a commercial food slicer with a sharp rotary blade easily accessible to potential residents. The back patio/ smoking area had food and spices stored next to pesticides. This area also contained non-functioning equipment including

refrigerators, freezers, microwaves, food service

Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING _ NVN4596HIC 01/04/2010

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MARY KNOLL CARE HOME		2000 HUMBOLDT STREET RENO, NV 89509					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
H 030 Continued From page 4			H 030				
	carts and bakery equipment.						
H 031	Safety & Sanitation -Furnishings		H 031				
	NAC 449.15525 Requirements for safety and sanitation of facility. (NRS 449.249) 2. A home must contain: (a) Appropriate and well-maintained furnishing						
	This Regulation is not met as evidenced by: Surveyor: 25375 Based on observations and interviews on 1/4 the home did not contain appropriate and well-maintained furnishings.						
	Findings include:						
	The carpeting in the living room was stained was covered with another piece of carpet. The employee reported it was covered due to extensive stains. The employee reported the original carpet was white, but observation revealed it was muddy grey to black in color couches and all chairs in the living room and dining area had numerous deep food stains the upholstery was ripped. There was excess furnishings in the living room/ dining area mait difficult to navigate safely through the room	The Both and ssive aking					
H 033	Safety&Sanitation-First Aid Kit		H 033				
	NAC 449.15525 Requirements for safety and sanitation of facility. (NRS 449.249) 2. A home must contain: (c) A first-aid kit;	d					
	are aited an approved plan of correction must be returned						

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
	NVN4596HIC			B. WING		01/04/2010			
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	1 0	00		
MARY KNOLL CARE HOME				HUMBOLDT STREET D, NV 89509					
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H 033	Continued From page 5			H 033					
	This Regulation is not met as evidenced by: Surveyor: 25375 Based on observation and interview on 1/4/10, the facility did not have a first aid kit.								
H 034	Safety&Sanitation-Food Preparation			H 034					
	NAC 449.15525 Requirements for safety and sanitation of facility. (NRS 449.249) 2. A home must contain: (d) Equipment that is sufficiently clean and adequate for the preparation, service and storage of food;								
	Surveyor: 25375 Based on observation equipment was not so	ufficiently clean and paration, service and sto							
	Findings include:								
	The oven door was mand counter spaces we dishes, utensils and comprehensils and comprehensils. The not filled with dirty dish	ed with dirty pots and po- nissing a handle. The sivere covered with dirty debris leaving no space e side of the kitchen sir shes, was backed up with the dining table was coatse.	ink for ik, th						
H 036	Safety&Sanitation-Te	emperatures		H 036					
	NAC 449.15525 Requisanitation of facility. (uirements for safety and NRS 449.249)	d						

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H 041

H 041 Records of Residents-Maintain file 5 years

basement/garage of the facility.

NAC 449.15527 Agreement between operator of home and resident concerning rates; maintenance of records of residents. (NRS 449.249)

This Regulation is not met as evidenced by:

Based on observation on 1/4/10, a portable space heater was being used as the sole source

of heat in each of the 2 bedrooms in the

The operator of a home shall:

Surveyor: 25375

2. Maintain a separate, organized file for each resident of the home and retain the file for 5 years after the resident permanently leaves the home.

This Regulation is not met as evidenced by: Surveyor: 25375 Based on observation, record review and separate, organized file for 5 years after 1 of 1 residents permanently left the facility (Resident

#1).

NAC 441A.375 Medical facilities, facilities for the

interview on 1/4/10, the facility failed to maintain a

H 050 Tuberculosis-Employees

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

H 050

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FORM APPROVED Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVN4596HIC 01/04/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2000 HUMBOLDT STREET MARY KNOLL CARE HOME **RENO. NV 89509** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) H 050 Continued From page 7 H 050 dependent and homes for individual residential care: Management of cases and suspected cases; surveillance and testing of employees; counseling and preventive treatment. 1. A case having tuberculosis or suspected case considered to have tuberculosis in a medical facility or a facility for the dependent must be managed in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 2. A medical facility, a facility for the dependent or a home for individual residential care shall maintain surveillance of employees of the facility or home for tuberculosis and tuberculosis infection. The surveillance of employees must be conducted in accordance with the recommendations of the Centers for Disease Control and Prevention for preventing the transmission of tuberculosis in facilities providing health care set forth in the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 3. Before initial employment, a person employed in a medical facility, a facility for the dependent or a home for individual residential care shall have (a) Physical examination or certification from a licensed physician that the person is in a state of good health, is free from active tuberculosis and any other communicable disease in a contagious stage; and (b) Tuberculosis screening test within the preceding 12 months, including persons with a history of bacillus Calmette-Guerin (BCG) vaccination.

If the employee has only completed the first step of a 2-step Mantoux tuberculin skin test within the preceding 12 months, then the second step of the

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any pulmonary symptoms develop. If symptoms of tuberculosis are present, the employee shall

be evaluated for tuberculosis.

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Based on record review on 1/4/10, the facility

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

provide personal care services in the home or a

to submit to the Central Repository for Nevada

complete sets of the fingerprints of the applicant.

bill imposes a similar requirement on a home for

respect to any person it hires or independent

This Regulation is not met as evidenced by:

home for individual residential care

Records of Criminal History two

(NRS 449.176) Section 5 of this

individual residential care with

(NRS 449.179)

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contractor with whom it contracts.

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managed his own funds, medications, laundry

Boarder #2 was a 65 year old male who stated he paid \$823.00 per month for a room and meals without a written agreement. He stated that he managed his own funds, medications, laundry

and personal care.

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